Accountable Care Organization (ACO) 101 Brief Course

Neil Kirschner, Ph.D.
Director, Regulatory and Insurer Affairs

What is an ACO?

ACO refers to a legal entity composed of a group of providers that assume responsibility (are accountable) to manage and coordinate care for a defined group of patients in an effective (high quality) and efficient (low cost) manner.

Major Elements of the Definition

- Has the legal ability and administrative organization to contract with payers.
- Is an entity governed by the participating providers.
- Is responsible for the care (typically total care) of a defined population.
- Is able to effectively measure the quality and efficiency of care delivery.
- Has payment aligned with the quality and efficiency of care delivered.

Brief History of ACO Development

Report of the Committee on the Costs of Medical Care (1932)

- Recommended integrated practice of medicine rather than autonomous individual set of practices.

Passage of the Federal HMO Act (1973)

- Encouraged the growth of prepaid medical groups (HMO) and Independent Practice Associations (IPA)

Growth of Managed Care (1990's)

- Sponsored by insurance plans that contracted with providers with payment to incent more efficient care. Payment often capitated --- with little or no provider protection from insurance risk. Little quality assurance. Significant public (against lock-in) and provider backlash.

CMS Physician Group Practice Demonstration (2005-10)

- Employed a shared saving model with clear evidence of improved quality and some evidence of lower cost.

Source: (Gold M. 2010)

Who can Form ACO?

Original concept promoted by Elliot Fisher at Dartmouth and MedPAC—would require hospital as a participating provider.

More recent development of the model broadens the nature of the ACO to consist of such collaborations as:

- **Group practices**
- **Integrated delivery systems (e.g. Geisinger)**
- **Networks of individual practices. (e.g. IPA)**
- **Partnerships or joint venture arrangements between hospitals and other providers (e.g. PHO)**
- **Hospitals employing other providers**
- **Regional Collaborations of health providers (NC Community Connections 646 Project)**

Basic Functions of an ACO: Clinical

Coordinate clinical efforts among all participating providers (e.g. primary care, specialists, inpatient facilities).

Facilitate the delivery of more effective and efficient care through increased care access, population management, care management and care self-management education.

Facilitate the ability to translate patient clinical and service use data to promote more effective care (E.g. define high use/high cost populations and establish clinical guidelines to more effectively care for these patients.

Basic Functions of an ACO: Administrative*

- Establish governance and administrative infrastructure
- Provide for enhance information technology and data analytic ability
- Develop prospective budgets and resource planning
- Establish relationships with participating and contracted providers
- Negotiate contracts with and submit claims to payers.
- Establish processes to manage risk (if appropriate).
- Establish and implement payment procedures to participating providers and contractees.(e.g., distribution of received shared savings.)

* ACO may hire or join with a Management Services Organization (MSO) to assist in providing these administrative functions.

Issues Regarding Who to Include within the ACO

<u>1.) Primary Care Providers</u>: Most healthcare policy leaders consider primary care as the *essential foundation* of an ACO --- preferred basis for attributing patients to the ACO (i.e. defining the population).

As the "first contact" and longitudinal care providers, primary care can affect quality and efficiency through:

- **Improved care access**
- **Prevention and early diagnosis**
- **Follow-up and coordination of chronic care treatment**
- **Limiting unnecessary specialty, ER and in-patient care**

Issues Regarding Who to Include within the ACO (cont.)

2.) Specialty Providers:

- **ACOs can choose to include various specialists within entity, or contract out for their services.**
- **For example: May include within the ACO those specialties that have frequent contacts with patients (endocrinologist; oncologist); AND/OR contract with specialists that typically do not have on-going relationship with patient (e.g. anesthesiologist, radiologist).**

Issues Regarding Who to Include within the ACO (cont.)

3.) Hospitals:

- Hospitals often have the necessary HIT, administrative infrastructure, and available capital to provide accountable care.
- In many communities, hospital employed physicians or practices make-up a large percentage of PC and specialty care providers --- recent survey; 65 % of hospitals planning to increase number of physician employed. (AHA 2010)
- Hospitals account for 40 % of growth in total healthcare spending (National Health Expenditure data).
- Key Questions include:
  - Does goal of ACO to reduce costs (particularly through reduction in unnecessary ER and hospital admissions) conflict with hospitals goals?
  - Is hospital willing to transform their business plan to be consistent with ACO goals?

Payment Options for ACO

1) Shared Savings:

- Based upon the extent that care expenditures of ACO on defined population compare to an established expenditure benchmark.
- Benchmark generally composed of risk adjusted estimated expenditures by payer on defined population if ACO wasn't in existence.
- Typically includes quality thresholds.

2) Partial Capitation/Bundled Payment Models:

- A bundled payment for provision of a group of services
  - e.g. the provision of a defined set of in-office primary care services for a year (Goroll Comprehensive Payment Model);
  - management for a condition for a year of Type 2 diabetes or an episode of pneumonia (e.g. Prometheus).
- Payments are based on an efficient provider analysis, typically risk adjusted and includes quality components.

Payment Options for ACO (cont.)

3) Full Capitation

- **Receives a set payment for each patient in the population. Payments are based on an efficient provider analysis, typically risk-adjusted and includes quality component.**

***** Note payment models address how ACO is paid; NOT how ACO will distribute funds to participating providers.**

ACO Shared Savings Model

Shared Savings can be implemented:

- With current payment system as foundation.
- To significantly limit degree of both insurance (illness severity of population) and performance (efficiency of service provision) risk accrued by participating providers
  - Thus, has potential to allow participation of a large number of providers.

ACO Shared Savings Model (cont.)

Based upon the extent that FFS care expenditures of ACO for defined population compares to an established expenditure benchmark. Two basic forms:

- **<u>One sided</u> --- only comes into effect if FFS payments to ACO are below benchmark. ACO can only share in savings; not at risk for "losses" (i.e. pay-back to payer) if FFS expenditures are above benchmark.**
  - **ACO still at risk for substantial start-up and operating costs with estimates ranging from $1 – 12 million.**
- **<u>Two sided</u> --- ACO contracts to share in savings if FFS care expenditures for defined population are below benchmark; and share in "losses" if FFS expenditures are above benchmark. ACO accrues risk.**

ACO Shared Savings Model (cont.)

One-sided model most appropriate for ACO new to collaborative payment models, small practice collaborations, collaborations with minimal access to capital and collaborations with minimal experience with risk contracts.

ACOs under two-sided model generally can earn higher percent of savings.

There are typically savings and loss corridors and limits e.g. expenditures must be at least 2 % above/below benchmark or savings/loss cannot be more than 10 % of total expenditures.

Components of ACO Shared Savings Model—Patient Attribution Overview

How to determine if patient falls within defined population of ACO.

Unless a closed panel system (e.g. HMO), generally based on utilization history of patient :

- **ACO defines list of participating providers to payer.**
- **Payer chooses provider designation to base attribution upon ---- typically based on primary care physicians or providers (may include some specialist designations if determination cannot be based upon primary care.)**
- **If patient under contract with payer receives a specified portion (a plurality) of services (e.g. E/M services) from designated provider within ACO, patient is attributed to that ACO.**

Components of ACO Shared Savings Model—Patient Attribution Approaches

Retrospectively--- based on whether patient met attribution utilization criteria during target year.

Pros:

- Ensures accuracy of attribution—only includes patients that actually met utilization criterion for target year.
- Encourages providers to treat all patients the same --- since may be included in attribution group.

Cons:

- Makes it difficult for ACO to track utilization and expenditure data and address specific needs of defined ACO population (accurate data only available after end of year)
- Makes patient notification and engagement difficult since neither patient nor participating ACO know if patient is within defined population until end of target year.

Components of ACO Shared Savings Model—Patient Attribution Approaches

Prospectively --- patient placed in defined ACO population based upon utilization history (e.g. last year or two) prior to target year.

Pros:

- Allows ACO to track utilization and expenditure data in a timely manner, make needed "mid-course changes, and address specific needs of defined ACO population.
- Allows for improved ability to inform patients of involvement in ACO and encourage their engagement in quality and efficiency processes.

Cons:

- Includes patients in defined population that do not meet utilization criteria during target year (e.g. did not get plurality of E/M services from provider used for attribution) and a significant amount of care may not have been under control of ACO (approximately 33 % of attributed population change each year).

Components of ACO Shared Savings Model—Patient Attribution Issues

While attribution is based on provider, the attribution is to the ACO and not the provider.

Once attributed, all the patient's expenditures are assigned to the ACO. The patient is typically free to receive care from any provider --- even those not participating within the ACO. Highlights the importance of patient engagement.

Policy makers encourage that providers by which attribution is based upon must be exclusive to a specific ACO --- to allow for clean population definition and reduce gaming (e.g. separating out high cost patients). All other providers can participate in multiple ACOs.

Must have an adequate number of patients within defined ACO population to provide statistically reliable cost and quality data. (A minimum of 5000 patients has been proposed in literature.)

Include as many payers as possible within program to increase patient penetration, provide increased incentive for practice to make required practice changes, and to decrease the problem of "free riders" (i.e. non-participating payers who benefit from practice changes that improve care quality and efficiency.

Components of ACO Shared Savings Model—Expenditure Benchmark Methods

1.) Cohort Comparison Group method --- compares expenditure data of defined ACO population with comparison population with similar demographic and health risk characteristics.

Pros:

- Allows for consideration of unexpected events/trends (e.g. epidemic) that take place during comparison year.

Cons:

- Difficult to develop reasonable cohort population e.g. defining ACO population may have a reactive effect on measures.
- Typically results in a long delay between end of performance year and results of data analysis.

Components of ACO Shared Savings Model—Expenditure Benchmark Methods

2.) Expenditure Projection method --- set at historic expenditure and utilization data for defined ACO population and project growth to determine benchmark.

Pros:

- Serves as its own internal control group
- Allows for on-going comparisons throughout performance year and ability to make procedural changes based on this data,

Cons:

- May be disadvantageous for low growth areas --- can be adjusted by using some combination of local and national growth trends.
- Not sensitive to unexpected events/trends.

Components of ACO Shared Savings Model—Quality Measurement

To ensure that quality is either maintained or improved during performance year, ACO programs include a quality threshold before entity can qualify for shared savings.

- **Measures should be endorsed by a nationally recognized multi-stakeholder consensus development organization (e.g. NQF);**
- **Preferably aligned with other performance measurement programs and across payers.**
- **Measures should cover broad spectrum of ACO activities including safety, clinical quality and patient experience of care**
- **Measures should be risk adjusted (where appropriate)**

Components of ACO Shared Savings Model—Quality Measurement

Data can be obtained through multiple methods:

- Administrative and claims data --- easiest to collect
- Patient registries
- Electronic clinical data --- can include clinical data from participating providers plus laboratory, pharmacy and related information.
- Patient Generated information --- experience of care surveys e.g. CAHPS

Several policy leaders have recommended that ACO performance data should be publicly reported to encourage trust within the defined ACO patient population and to encourage performance improvement when compared to similar provider entities.

Components of ACO Shared Savings Model—Incentive Distribution

Governance of ACO must determine how the incentive (savings) is to be shared by participating providers.

Before distributing out incentives, ACO must retain an amount of the eligible shared savings to cover start-up and operating costs.

Remaining savings in incentive pool can be distributed based on some combination of models including:

- Degree to which provider directly contributed to improved care quality and efficiency.
- Degree to which provider lost revenue as a result of patient management procedures implemented by ACO.
- Return of capital based upon ACO investors or partners capital contribution.

ACO Legal Issues

ACO participating practices collaborate and form a legal structure to contract with payers. This activity may accrue risk of violating a number of federal and state laws and regulations that can result in criminal and/or civil penalties. Important to obtain good legal advice when forming an ACO.

ACO Legal Issues – Relevant Laws and Regulations

- Federal Antitrust Law
- Federal Physician Self Referral (Stark) Law
- Federal Anti-Kickback Law
- Federal Services Reduction and Beneficiary Inducement Civil Monetary Penalty Laws

Primary Elements of Medicare Shared Savings Program Final Rule

Voluntary Program—built on FFS model

Approved ACOs contract directly with Medicare

Participating Provider Composition Can Take Many Forms---hospital participation not required

Governing Body must have at least 75 percent representation from participating providers

- Must have beneficiary representation
- Clinical management and oversight are managed by a senior-level medical director

Primary Elements of Medicare Shared Saving Program Final Rule

Two Tracks

- One sided No risk 50 percent share savings
- Two-sided Risk yearly 60 percent share savings

Prospective Attribution with Reconciliation -- Hybrid Assignment

- Plurality of primary care services from defined primary care physicians (i.e. .internal medicine, family practice, general practice, geriatric medicine)
- Plurality of primary care services from at least one physician and other ACO healthcare professionals (i.e. physician assistant, nurse practitioner or clinical nurse specialist)
- Reconciliation at end of year --- 3 month roll-out.
- 5000 beneficiary minimum

Primary Elements of Medicare Shared Saving Program Final Rule

Expenditure Baseline

- Based on previous 3 years of risked adjusted expenditures from initially attributed beneficiaries (local).
- Yearly adjustments made for changes in population (risk adjustment) and national growth rate.

Savings/Losses Determination

- Difference from expenditure baseline
- Minimum and maximum limits
- Performance on quality measures
- First dollar once minimum is reached

Primary Elements of Medicare Shared Saving Program Final Rule

Quality Measures

- 33 quality measures
- Four key domains: patient/caregiver experience, preventive health, care coordination/patient safety and at-risk populations.

Protection from Federal Antitrust, Self-referral, Kickback and Civil Monetary Penalties (i.e. gainsharing and beneficiary inducement)

Advanced Payment Model

- Demonstration project through CMMI
- Focus on physician owned, small and rural practice ACOs

ACO Participation
Factors to Consider

- What representation will I have on governance?
- What are the administrative and organizational requirements (e.g. data submission, committee participation)?
- What practice transformation changes will be required (e.g. EHR, 24/7 access, case management) ?
- What financial and "in-kind" assistance can I expect from the ACO with required transformation?

ACO Participation
Factors to Consider

- What are reasonable estimates of shared savings that the ACO can earn?
- How will the shared savings be distributed?
- Is there a potential to accrue losses and have to participate in a "pay-back"? What is my maximum risk?
- Is the ACO adequately protected from Federal and State Penalties (e.g. Antitrust, Kickback)?

Primary Presentation Sources

Brookings Institution. The Accountable Care Organization Toolkit. 2011. Available at www.acolearningnetwork.org

Gold M. Accountable Care Organizations: Will They Deliver? 2010. Mathematica Policy Research Inc. Available at http://www.mathematica-mpr.com/publications/pdfs/health/account_care_orgs_brief.pdf

Miller H. How to Create Accountable Care Organizations. 2009. Center for Healthcare Quality and Payment Reform. Available at http://www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf

CMS Medicare Shared Savings Final Rule. Available at http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf

Other Useful ACO Information and Tools

Available at the ACP ACO Website at:

http://www.acponline.org/running_practice/aco/

This site will be actively updated as new information becomes available and more ACO-enabling tools are developed.

Questions?

Neil Kirschner Ph.D
Senior Associate, Regulatory and Insurer Affairs
nkirschner@acponline.org
202-261-4535